BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Steven Ivan Popkow, M.D.	)	**Case No. 800-2016-023561**
Physician's and Surgeon's Certificate No. G 62006	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 5, 2019.

IT IS SO ORDERED: August 6, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STEVEN IVAN POPKOW, M.D.,** **Physician's and Surgeon's Certificate No. G 62006,** Respondent.	Case No. 800-2016-023561 OAH No. 2018050294

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on June 4 through 7, 2019, in Los Angeles.

Brian D. Bill, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Respondent Steven Ivan Popkow, M.D., appeared and represented himself.

Complainant's motion to exclude expert testimony for respondent was granted, on the grounds stated in the pre-hearing motion.

Oral and documentary evidence was received. The record was closed and the matter was submitted on June 7, 2019.

Protective Order

The ALJ issued a protective order sealing exhibits to protect confidential information concerning third parties. Redaction of those documents subject to the protective order to obscure confidential information was not practicable and would not have provided adequate privacy protection. Those exhibits shall remain under seal and shall not be opened, except by order of the Board, by OAH, or by a reviewing court. The ALJ ordered that every court reporter refer in the hearing transcript to respondent's patients by initials only.

SUMMARY

Complainant seeks to discipline respondent's medical license on grounds of alleged excessive prescribing, prescribing without indication, gross negligence, repeated negligent acts, incompetence, inadequate and inaccurate recordkeeping, and unprofessional conduct in connection with care and treatment provided to two patients. Respondent denies the allegations and asserts cause for discipline does not exist.

FACTUAL FINDINGS

Jurisdiction

1. Complainant filed the Accusation in her official capacity. Respondent timely filed a notice of defense.

2. The Board issued Physician's and Surgeon's Certificate No. G 62006 to respondent on December 14, 1987. Respondent's certificate was in full force and effect at all relevant times and is scheduled to expire on December 31, 2019. Respondent's medical certificate has not previously been disciplined.

Expert Witnesses

3. Complainant called Kristin S. Peña, M.D. as an expert witness. Dr. Peña received her medical degree from Michigan State University College of Human Medicine in 1997, and she performed a residency in family medicine at Franklin Square Hospital in Baltimore from 1997 to 2000, serving as Chief Resident from 1999 to 2000. She was certified by the American Board of Family Medicine in 2000 and recertified in 2017. She was licensed in California in 2001 and has had an active Drug Enforcement Administration (DEA) license since 1999. She serves as part-time core faculty for the family medicine residency at Community Memorial Hospital, works as a part-time family physician at the Santa Barbara Neighborhood Clinics in Isla Vista, and serves as a medical consultant and expert reviewer for the Board.

4. Respondent called no expert witnesses.

Patient B.L.L.[1] *and Expert Testimony*

5. Patient B.L.L. was 53 years old when he first presented to respondent on September 10, 2012, with back pain and radicular leg pain (pain radiating from the spine down the distribution of the impinged nerve), some numbness, and changes in urination. He reported a prior diagnosis of a herniated disc in his lumbar spine. He also reported that he took his father's prescription Vicodin up to four times per day. Respondent and a medical

[1] Initials have been used for all patients to protect their confidentiality.

student assisting him in the intake examination each wrote portions of the medical record. Respondent saw and treated Patient B.L.L. over a course of 25 approximately monthly visits, through January 8, 2016.

6. Dr. Peña testified in support of complainant's allegations of excessive prescribing, prescribing without indication, gross negligence, repeated negligent acts, incompetence, inadequate and inaccurate recordkeeping, and unprofessional conduct in his treatment and care of Patient B.L.L. Referring throughout her testimony to Patient B.L.L.'s medical records, she testified that, over the course of treatment, respondent failed to perform an adequate history or physical examination as to B.L.L.'s back pain or confirm a definitive diagnosis for the patient's chronic back pain; document or recommend physical therapy or other treatment modalities or alternatives to opiates; require B.L.L. to sign a controlled substance agreement; monitor CURES reports to determine the extent of B.L.L.'s opiate use; screen B.L.L. for symptoms of abuse or misuse of opiates despite the presence of indicators; and address various objective signs and symptoms of opiate misuse. (Ex. 1, Accusation, ¶¶ 32-37.)

7. In her expert report, which she adopted as true and correct at hearing, and in her testimony, Dr. Peña opined that:

a. Respondent's evaluation of Patient B.L.L.'s back pain was an extreme departure from the standard of care and demonstrated incompetence, in that respondent never performed an adequate history or physical examination in over 25 visits and never obtained any testing to confirm a definitive diagnosis for the patient's back pain. There is no way to know whether B.L.L. had a herniated disk, as no tests were done; without those tests, he should not have been prescribed any narcotics. Prescribing narcotics without indication and proper documentation deviates substantially from the standard of care.

b. Respondent's treatment of the patient's back pain constituted an extreme departure from the standard of care and demonstrated incompetence, in that respondent offered no treatment for the patient's back pain other than narcotics. Prescribing opiates without determining their true impact on the patient's body is creating functional addicts, like B.L.L., who functioned well because of the prescribed drugs.

c. Respondent's prescribing of opiates for the patient without assessing the patient for misuse or diversion, without monitoring the patient by using CURES reports or by drug testing, failing to document counseling regarding the risks of opiate medications, and failing to enter into a controlled substance agreement with the patient, constituted an extreme departure from the standard of care. His failure to identify the patient's non-compliance with his requests that the patient obtain an MRI and the patient's illegal use of his father's opiate medication as red flags for potential opiate dependence demonstrated incompetence.

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d. Respondent's inaccurate and illegible medical records for this patient, especially the lack of any documented history or recommendations, is an extreme departure from the standard of care.[2]

e. Respondent's prescribing without indication constituted simple or extreme departures from the standard of care and demonstrated incompetence:

i. Respondent engaged in an extreme departure from the standard of care when he prescribed thrice-daily benzodiazepines to the patient, ostensibly to treat anxiety and insomnia, when the patient lacked any significant history of anxiety or insomnia and did not present with symptoms, and without recommending alternative therapies, counseling, other sleep agents, lifestyle measures, or non-controlled medications, without requiring the patient to sign a controlled substances agreement, without documenting any discussion of the risks of using benzodiazepines even though the patient reported drinking alcohol, without performing toxicology screenings or monitoring CURES reports, and without counseling the patient that benzodiazepines are not approved for long-term use.

ii. Respondent engaged in a simple departure from the standard of care when he prescribed testosterone therapy, ostensibly because the patient presented with a history of low testosterone, even though the patient never presented with any symptom consistent with low testosterone levels, respondent did not document any medical justification for prescribing testosterone, the patient reported he was not sexually active, respondent never counseled the patient about the possible side effects of testosterone therapy, respondent never performed a second prostate examination after the one performed at the patient's initial visit was abnormal, and respondent did not consider whether the patient's low testosterone levels were due to opiate therapy.

iii. Respondent engaged in a simple departure from the standard of care when he failed to follow up on the patient's abnormal prostate examination.

iv. Respondent engaged in a simple departure from the standard of care when he failed to evaluate and manage on the patient's elevated blood sugar.

8. Respondent disputed Dr. Peña's opinion that respondent failed to perform an adequate history or physical examination and never obtained testing to confirm a definitive diagnosis for the patient's back pain. Respondent testified that his diagnosis of back pain was based on the patient's subjective statements supplemented by the patient's clinical history, the physical examination, and respondent's interactions with and observations of the patient

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[2] In her report, Dr. Peña also assessed respondent's supervision of medical students, finding respondent engaged in a simple departure from the standard of care because the patient's chart did not clearly reflect whether entries were made by medical students or by respondent. (Ex. 6, p. 636.) The Accusation does not charge respondent with inadequate supervision; this opinion, therefore, will be considered as being offered in support of allegations concerning respondent's recordkeeping.

during office visits. He concluded the back pain was mostly work-related, due to respondent's lifting and moving of heavy items and repetitive motion. Patient B.L.L. had several jobs, including managing a large sporting goods store, which involved lifting of heavy packages, a significant factor in his pain. He was concerned about being able to function at work. He had a side job of commercial fishing, and was sometimes out for days on fishing boats. Respondent also looked for a possible non-musculoskeletal cause for the patient's back pain. B.L.L. had received a spine workup at St. John's Hospital five years before seeing respondent; the patient told respondent that doctors there had recommended invasive procedures, which he refused. The patient told respondent he wanted no invasive procedures because they would interfere with his work routine; that is why he refused to have an MRI performed, despite respondent's repeated recommendation that he do so. Respondent conceded that not everything that was examined or discussed is written in the record, but asserted that these omissions are common in medical practice.

9. Addressing Dr. Peña's opinion that respondent offered no treatment for the patient's back pain other than narcotics, respondent testified that the patient refused any invasive treatment or diagnostic tests such as an MRI that might lead to an invasive treatment. The patient also refused an epidural, because the effects would be transient and might affect other joints. Respondent testified he asked the patient whether he had tried over-the-counter products or physical therapy; the patient said he had taken non-steroidal anti-inflammatory medications (NSAIDs) in the past, with some limited benefits. Respondent believed NSAIDS were not appropriate for patient B.L.L. due to the patient's heart and blood pressure issues. The patient had used narcotic analgesic in the past with good results, so respondent prescribed Norco, which is indicated for moderate to severe pain, is safe, and has been used by the medical community for years, formerly in the form of Vicodin, which contains more Tylenol. Respondent used pain scales in his charts to document whether medications were helping over time. The patient rated his pain 8/10 while off medications, and 2/10 while on medications. Respondent testified that any score chronically above 5 or 6/10 may require treatment with narcotics. Respondent continued to refill the Norco prescriptions during the patient's monthly visits in order to control the patient's pain; respondent did not expect the pain to cease completely, due to the patient's age, weight, and other factors.

10. Respondent addressed Dr. Peña's opinion that respondent prescribed opiates without assessing the patient for misuse or diversion, or monitoring the patient, or failing to document counseling regarding the risks of opiates, or entering into a controlled substance agreement.

a. Respondent testified that CURES documentation was available in 2012 but, in the community in which he practices, most doctors did not routinely refer to it, and he does not believe CURES reports were accurate then or that they are entirely accurate today. Respondent did not assess the accuracy of CURES reports for this patient, however. Before 2016, when the use of CURES was mandated, respondent relied on pharmacists to alert him to medication issues of concern. In 2016, he could have asked B.L.L.'s pharmacist to run a CURES report on the patient, but he did not do so. Respondent screened the patient for a

possible substance abuse history; B.L.L. denied any problem with alcohol or drugs. Respondent ordered a urine drug screen early in his treatment of the patient to see whether he was using other, illicit substances and to see whether he was taking his prescribed medications.

b. B.L.L. told respondent he had been using his father's prescription Vicodin. This caused respondent concern; he testified he advised the patient that it was a felony and that he should obtain his own prescription if the medication was appropriate for him. It did not, however, cause respondent to suspect drug-seeking behavior; the patient sought primary care, complained of pain, and told respondent what had worked for him. He did not ask for a narcotic. Nor did respondent consider the patient's refusal to obtain an MRI to elucidate possible causes of his back pain as a red flag for drug misuse. Caring for B.L.L. for multiple years, respondent never had any concern about whether he was abusing the prescribed drugs; the patient never sought the drugs from other doctors and he was compliant with respondent's treatment plan, e.g., with blood testing.

c. Respondent acknowledged that he did not use a written controlled substance agreement, but maintained that he obtained verbal informed consent.

11. Respondent acknowledged numerous examples of his failure to keep accurate, legible, or complete medical records for Patient B.L.L. Respondent conceded that not everything he discussed with patient B.L.L. is in his medical records. Respondent does not use electronic medical records; he can discern from the handwritten entries whether a notation was made by him or by his medical student assistant, though he could not ascertain from the notes which of them drew the patient's blood, or took the patient's history, or conducted the physical examination, for example. Respondent acknowledged that some of his notations, such as drawing an arc or crescent alongside pre-printed text to indicate normal results, is not standard notation. Respondent diagnosed anxiety on April 5, 2013, but did not notate how often or how long the patient experienced anxiety, or potential life stressors that could be causing it, or anything about restlessness, fatigue, difficulty concentrating, or irritability, or whether anxiety was impairing the patient's functioning; respondent acknowledged that information should be considered when diagnosing anxiety. Respondent contested that a subsequent treating physician would see no substance behind the diagnosis, because the diagnosis of anxiety would mean that all those diagnostic criteria were present. Nevertheless, respondent acknowledged that he would tell his students to include more information and detail than he did, and that his notes were minimal. Respondent testified he has never received complaints from other providers, medical students, or insurance companies about his documentation. Respondent conceded that, to diagnose insomnia, it would be important to note how long the patient is awake each night, but he did not document that. Very little was documented regarding B.L.L.'s back, insomnia, and anxiety; instead, the records contain largely conclusory statements about symptoms and diagnoses. Prescriptions without indication flow from these charting deficiencies. Dr. Peña testified that nothing in the medical records warranted opioids or benzodiazepines for four years, and the records do not reveal the basis for the diagnoses of back pain or insomnia.

12. Addressing Dr. Peña's opinion that he prescribed benzodiazepines without indication, respondent testified that patient B.L.L. described difficulty sleeping at night due to back spasm pain. Because of the patient's obesity, hypertension, insomnia, and symptoms of anxiety and poor sleep, respondent wanted to order a sleep study. The patient refused, because he did not want to use the treatment, i.e., a CPAP machine. Respondent, therefore, decided to give the patient a benzodiazepine to relax his back. He testified that benzodiazepines are commonly prescribed for sleep, anxiety, and muscle relaxation. The records indirectly show that the patient's anxiety improved, by mentioning that he was performing at work at a high level, vacationing and fishing, and sleeping well. These were the goals of treatment with benzodiazepine. Respondent testified he discussed insomnia and sleep hygiene issues with the patient; this is not reflected in the medical records.

13. Addressing Dr. Peña's opinion that he prescribed testosterone therapy without indication, respondent testified that, on December 3, 2013, the patient presented with low testosterone. Low testosterone affects bone, muscle mass, mood, and metabolism, and patients usually benefit from testosterone replacement therapy. Patient B.L.L. took it for a while, did not feel better, and stopped.

14. The medical records and the evidentiary record as a whole supports Dr. Peña's testimony and opinions. Complainant established by clear and convincing evidence that respondent engaged in excessive prescribing (based on sketchy documented support for the prescriptions), prescribing without indication, gross negligence, repeated negligent acts, incompetence, inadequate and inaccurate recordkeeping, and unprofessional conduct in his treatment and care of patient B.L.L.

Patient M.C. and Expert Testimony

15. Patient M.C., born in 1992, saw respondent for about 10 years, from 2006 to 2016, for treatment of multiple medical issues, including fractures of his left wrist and ankle, Attention Deficit Hyperactivity Disorder (ADHD), neck pain, back pain with spasms, left sciatica, and scoliosis of 11 degrees. Patient M.C. was a smoker and had a family history of chronic pain and arthritis in both parents. Over the course of treating Patient M.C., respondent prescribed and refilled prescriptions of Norco, Soma, and Adderall.

16. Dr. Peña testified in support of complainant's allegations of excessive prescribing, prescribing without indication, gross negligence, repeated negligent acts, incompetence, inadequate and inaccurate recordkeeping, and unprofessional conduct in his treatment and care of Patient M.C. in that, over the course of treatment, he performed one Adult Attention Deficit Scale with respect to the patient but inadequately documented it; failed to perform an adequate history of proper psychological testing to properly diagnose M.C. with ADHD; never required M.C. to sign a controlled substance agreement; never monitored CURES reports to determine the extent of M.C.'s opiate use; performed one toxicology screening on M.C., on December 13, 2007, which was negative for opiates and stimulants, but during the remainder of the treatment period respondent prescribed opiates to M.C. without ever performing a toxicology screening to determine the extent of M.C.'s

opiate use; and failed to address various objective signs and symptoms of opiate misuse. (Ex. 1, Accusation, ¶ 45; see also ¶¶ 81-86.)

17. In her expert report, which she adopted as true and correct at hearing, and in her testimony, Dr. Peña opined that:

a. Respondent engaged in an extreme departure from the standard of care in prescribing opiates for the patient without assessing the patient for misuse or diversion, without monitoring the patient by using CURES reports or by drug testing, and without entering into a controlled substance agreement with the patient.

b. Respondent's inaccurate and illegible medical records for this patient, especially the lack of any documented history or physical examination, is an extreme departure from the standard of care. The records reveal no indication or documentation regarding respondent's diagnosis of ADHD. And there was no objective reason for respondent's initial prescription of opioids; until M.C. received an MRI in late 2016, there was no documented cause for the alleged pain.

c. Respondent engaged in an extreme departure from the standard of care by taking an inadequate history regarding patient complaints relating to attention deficits, by failing to review and apply the Diagnostic and Statistics Manual criteria for ADHD, and by failing to monitor stimulant therapy.

d. Respondent engaged in a simple departure from the standard of care by prescribing Augmentin, a strong broad-spectrum antibiotic, for what appears from the records to be a likely viral illness. On April 17, 2015, the patient presented with a sore throat, which he had not had long. He had no fever, and normal blood pressure and pulse. Respondent prescribed Augmentin, an antibiotic, without performing a proper workup or determining that the patient had a bacterial infection; he asked no questions about smoking, fever, dental issues, and other relevant matters, and documented no tender nodes. Respondent drew a crescent mark next to the physical examination elements, indicating in his idiosyncratic way that all was normal.

18. Respondent addressed Dr. Peña's opinion that he engaged in an extreme departure from the standard of care in prescribing opiates for the patient without assessing the patient for misuse or diversion, without monitoring the patient by using CURES reports or by drug testing, and without entering into a controlled substance agreement with the patient.

a. The patient was a professional trick bicycle rider; his career involved jumps off of buildings and down flights of stairs, resulting in tremendous pressure on his back and spine, magnified by his scoliosis, and leading to traumatic changes and arthritis. During a visit in August 2013, when the patient was 21 years old, he complained of acute lumbar sprain and a bruised thigh; he rated his pain at 8/10, which is severe. Respondent prescribed Vicodin ES, Motrin, and Soma, a common muscle relaxer, to relieve some of the pain. When Norco was developed to reduce the amount of Tylenol, respondent prescribed

Norco instead of Vicodin. In August 2015, when M.C. had an acute flare-up of back pain, which he rated at 9 or 10/10, respondent refilled the patient's prescriptions with Norco and Soma. The patient, respondent testified, only took the medications when he was in pain, so the one-month prescriptions lasted for months. Respondent saw the patient roughly monthly through 2016 and 2017, treating his continuing back pain and referring the patient to a pain specialist, Dr. Bajaj, in 2016, after obtaining MRI results, and 2017.

b. Respondent instructed M.C. to use only one pharmacy, so the pharmacist would get to know respondent. A pharmacist might be concerned because of narcotics prescribed to one so young, and would likely run a CURES report. But at that time, respondent testified, the CURES system was not running at its full potential and there were questions about its accuracy and reliability. Respondent again testified that CURES reports are not accurate. One CURES report, for example, showed Patient M.C. receiving 270 units of Suboxone dispensed by another doctor, an incredibly high quantity to give anybody. The patient told respondent his family health identification number was stolen and that he was informed by a pharmacist that somebody else was picking up medications, under his name, that he had not ordered. Respondent testified that CURES is set up to "entrap" doctors, and that he suspects many doctors are violating the "gotcha" system.

c. In 2017, M.C. received an epidural steroid injection at L5-S1 from a Dr. Cunningham due to his experiencing 10/10 pain. But the pain kept escalating, so M.C. took some extra doses of Soma. He was taken to the UCLA Santa Monica emergency room, where he was treated with Lorazepam, a benzodiazepine, as an adjunct to his pain treatment. Respondent maintained there is no evidence in the record of treatment of M.C. of opiate intoxication. After the emergency room visit, respondent referred M.C. to Dr. Bajaj for opiate management and treatment. Eventually the patient was referred to Dr. Nomoto for surgery, due to severe pain that was not responding to conservative medical treatment (opiates, medical marijuana, muscle relaxants). X-rays showed L4-S1 spondylosis; an MRI showed an extruded disk at L4-5 and impinged nerve roots, indicating surgery.

d. Respondent performed a preoperative examination: He testified that, in 25 years of practice, no hospital or provider has ever rejected his notes. After the surgery, M.C. had 9/10 pain and spasms underneath the incision, which was reduced to 4-5/10 for a few hours with medication, so respondent refilled the Soma prescription. After M.C. was injured in an automobile accident in June 2017, respondent referred him again to Dr. Nomoto. Respondent added some Percocet to the patient's pain management regime, because his pain was 8/10.

e. In January 2017, respondent had M.C. sign a controlled substance contract. After 2016, respondent had access to a computer for the first time, and checked most patients' CURES report every visit, again noticing some inaccuracies in the reports. He does not include a copy of the CURES report in the patients' charts, because it is not reliable and can hurt the patients with their insurance companies.

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f. Not until 2016 did the Food and Drug Administration issue a black box warning for using benzodiazepine and opiates together. Respondent testified he always monitored his patients, especially if they were on both medications. Chronic pain causes anxiety and depression; the goals of treatment are to get patients functioning, back to work, and doing things that give them joy. Respondent prescribes short-acting opioids in doses under 100 morphine equivalent units per day, which is acceptably low. Respondent testified that in retrospect he should have treated M.C. more aggressively for pain; he had erred on the side of less medicine instead of enough, so M.C. did not benefit as much as he could have from pain management. Benzodiazepines and opioids are safe, but because hydrocodone can be addictive it is important to follow up with long-term users, as respondent does monthly.

19. Respondent addressed Dr. Peña's opinion that he took an inadequate history regarding M.C.'s complaints relating to his attention deficit issues, failed to review and apply the appropriate criteria for ADHD, and failed to monitor stimulant therapy. Respondent testified that patient M.C. presented with a history of ADHD symptoms and brief treatment with Ritalin in elementary school, which he stopped due to the medication's side effects. Respondent verified the history with the patient's parents, who were also respondent's patients. When the patient became an adolescent, he began seeing respondent, who treated him episodically for acute issues. On August 19, 2015, respondent first gave M.C. Evekeo, an amphetamine, for ADHD. M.C.'s bicycle-riding career was winding down due to pain and he was working extended hours in a studio job that required mental focus. ADHD patients require medications to allow them to focus and continue working. Respondent testified M.C. was able to advance in his career because of respondent's treatment, and M.C. experienced no significant side effects from the medication.

20. Respondent addressed Dr. Peña's opinion that he kept inaccurate and illegible medical records for this patient, and failed to document the patient's history and physical examination. He conceded that the records may not show how long M.C. experienced symptoms of ADHD, nor what areas of daily life the condition affected. The medical record is vague as to the date M.C. received an epidural. When respondent first started treating M.C. with opioids in 2013, respondent conducted a spinal exam but did not record what he did to examine M.C.'s back. On April 17, 2015, and other dates, he did not document in his progress notes prescriptions for opioids for M.C. He usually documents that, he testified, by keeping a copy of the triplicate prescription form, and generally does not mention it in his progress notes. Nor did he consistently notate back pain. He prescribed Norco and Soma for severe lumbar pain and spasm in August 2013, and refilled the prescriptions in August 2015. Respondent explained the two-year gap between prescriptions, testifying that the patient stretched out his initial prescription by using the medications only when he was in pain. He acknowledged that this is not noted anywhere in the records. Respondent documented areas of pain by drawing squiggles on a stick figure, but never notated that he palpated the patient.

21. Respondent addressed Dr. Peña's opinion that he engaged in a simple departure from the standard of care by prescribing Augmentin for a likely viral illness. Respondent testified that Dr. Peña "nitpicked" his antibiotic therapy, revealing her biased agenda to cure the opioid crisis "on my back."

22. The medical records and the evidentiary record as a whole supports Dr. Peña's testimony and opinions. Complainant established by clear and convincing evidence that respondent engaged in excessive prescribing (based on sketchy documented support for the prescriptions), prescribing without indication, gross negligence, repeated negligent acts, incompetence, inadequate and inaccurate recordkeeping, and unprofessional conduct in his treatment and care of patient M.C.

LEGAL CONCLUSIONS

Burden of Proof

1. The rigorous education, training, and testing requirements for obtaining a physician's license justify imposing on complainant a burden of proving her claims by clear and convincing evidence. (Evid. Code, § 115; see *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; *Imports Performance v. Dept. of Consumer Affairs, Bur. of Automotive Repair* (2011) 201 Cal.App.4th 911.)

Applicable Authority

2. The Board is responsible for enforcing the disciplinary provisions of the Medical Practice Act (Bus. & Prof. Code, § 2004, subd. (a)). The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.) A certificated practitioner who violates the Medical Practice Act may have his or her certificate revoked or suspended or placed on probation, be publicly reprimanded, or have "other action taken in relation to discipline" as the Board deems proper. (Bus. & Prof. Code, § 2227.)

3. The Board may discipline a practitioner's certificate for unprofessional conduct, which includes, among other things, any violation of the Medical Practice Act, gross negligence, repeated negligent acts, incompetence, and failure to maintain adequate and accurate records of services provided to patients. (Bus. & Prof. Code, §§ 2234, subds. (a)-(c), 2261, 2266.) It is a violation of the Medical Practice Act to excessively prescribe controlled substances or to prescribe them without an appropriate prior examination and a medical indication. (Bus. & Prof. Code, §§ 725, 2241.5, subds. (c), (d), 2242; see Health & Saf. Code, § 11153.)

Causes for Discipline

4. Cause exists to discipline respondent's certificate under Business and Professions Code sections 725 and 2241.5, subdivisions (c) and (d), for prescribing excessive amounts of schedule II substances to Patients B.L.L. and M.C., by reason of Factual Findings 5 through 22 and Legal Conclusions 1 through 3.

5. Cause exists to discipline respondent's certificate under Business and Professions Code section 2242 and Health and Safety Code section 11153, for failing to perform adequate examinations of Patients B.L.L. and M.C. prior to continuously prescribing

to them Schedule II substances, by reason of Factual Findings 5 through 22 and Legal Conclusions 1 through 3.

6. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (b), for engaging in gross negligence in connection with the care and treatment provided to Patients B.L.L. and M.C., by reason of Factual Findings 5 through 22 and Legal Conclusions 1 through 3.

7. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (c), for engaging in repeated negligent acts in connection with the care and treatment provided to Patients B.L.L. and M.C., by reason of Factual Findings 5 through 22 and Legal Conclusions 1 through 3.

8. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (d), for engaging in departures from the standard of care constituting incompetence in connection with the care and treatment provided to Patients B.L.L. and M.C., by reason of Factual Findings 5 through 22 and Legal Conclusions 1 through 3.

9. Cause exists to discipline respondent's certificate under Business and Professions Code section 2266 for inadequate and inaccurate recordkeeping in connection with the care and treatment provided to Patients B.L.L. and M.C. by reason of Factual Findings 5 through 22 and Legal Conclusions 1 through 3.

10. Cause exists to discipline respondent's certificate under Business and Professions Code section 2234, subdivision (a), for general unprofessional conduct in connection with the care and treatment provided to Patients B.L.L. and M.C. by reason of Factual Findings 5 through 22 and Legal Conclusions 1 through 3.

11. The purpose of a disciplinary action such as this is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) The evidence on the whole does not establish that respondent is incapable of rectifying his deficiencies, many of which seem to have their root cause in inadequate recordkeeping. With appropriate terms of probation, respondent will not be likely to pose a threat to the public or to his patients and will be able to practice in a manner consistent with the standard of care.

ORDER

Physician's and Surgeon's Certificate No. G 62006, issued to respondent Steven Ivan Popkow, M.D., is hereby revoked. The revocation is stayed, however, and respondent's certificate is placed on probation for five years on the following terms and conditions:

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1. Notification

Within seven (7) days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court-ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

12. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

13. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

14. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's physician assistant supervision practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's physician assistant supervision practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of

respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

DATED: July 8, 2019

DocuSigned by:
Howard W. Cohen
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HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Steven Ivan Popkow, M.D.** **12099 W Washington Blvd** **Suite 400** **LOS ANGELES, CA 90066-5882** **Physician's and Surgeon's Certificate No. G 62006,** Respondent.	Case No. 800-2016-023561 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about December 14, 1987, the Medical Board issued Physician's and Surgeon's Certificate Number G 62006 to Steven Ivan Popkow, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2017, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon

order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under

restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

4. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

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STATEMENT OF FACTS

Patient B.L.L.

Initial Visit

10. On or about September 10, 2012, patient B.L.L.[1] presented to Respondent, and a medical student supervised by Respondent, for a physical examination. Prior to this appointment, B.L.L. stated that he had not sought regular medical care for approximately five years. During the course of the appointment, B.L.L. reported that he experienced back pain and changes in his urine stream. The medical student noted that B.L.L. stated his back pain radiated to his left shin and caused some numbness. B.L.L. reported a prior diagnosis of a herniated disc in his lumbar spine. B.L.L. reported that he took his father's prescribed Vicodin up to four times per day. A checklist Review of Systems (ROS) completed by the patient noted occasional neck pain, blurry vision, chest pain, urine symptoms and frequent severe back pain, leg pain, and restless sleep. Another checklist noted that B.L.L. occasionally felt nervous, had trouble relaxing, and frequently felt "hurried." B.L.L. also reported on this form that he did not have trouble sleeping. The intake form noted he drank alcohol. Respondent did not note any issues with stress or difficulty sleeping in the treatment notes.

11. B.L.L. urinalysis was normal and his blood pressure was 180/96 in the left arm and 156/90 in the right. B.L.L.'s weight was 184 pounds with a Body Mass Index (BMI) of 27. The documented exam by the medical student noted enlargement of the prostate. The remainder of the exam documented by the medical student was essentially normal other than mild edema.[2] The medical student documented regarding the back examination "Sens: intact, Motor: intact."

12. The assessment included "Hypertension,[3] Herniated disc, Urinary urgency, Overweight." The plan, written in two distinct handwritings styles, included urinalysis, blood draw, colonoscopy, MRI of the spine, EKG, Tetanus booster, and prescriptions for Norco[4] 10/325

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[1] Patient's initials are used to protect patient privacy.

[2] A condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body.

[3] Abnormally high blood pressure.

[4] This combination medication is used to relieve moderate to severe pain. It contains an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen).

one tablet four times a day #90, Dalmane (flurazepam)[5] 30 mg once at night, #30, presumably for sleep, and Norvasc/amlodipine mg one twice a day for blood pressure.

13. During the initial visit, Respondent did not require B.L.L. to sign a controlled substance agreement. Moreover, Respondent did not generate and/or review a CURES report to independently verify B.L.L.'s narcotic use.

14. In discussing the above appointment during the June 13, 2017 interview, Respondent stated that he counseled B.L.L. regarding lifestyle measures to improve his weight and blood pressure. Respondent failed to document this conversation in the treatment notes.

Subsequent Visits

15. B.L.L. was seen again on September 24, 2012. Respondent failed to note a chief complaint or History of Present Illness (HPI) in the treatment notes. B.L.L.'s blood pressure was 148/86. The only physical exam noted was a "crescent mark" drawn through the entire pre-stamped physical form. During the June 13, 2017 subject interview, Respondent stated that the "crescent mark" is his shorthand for "unremarkable." The Assessment and Plan was essentially similar to the previous visit. B.L.L. failed to complete the MRI Respondent prescribed during the initial visit.

16. B.L.L. was seen again on October 10, 2012, November 7, 2012, and December 15, 2012. Respondent's charting of these visits was similar to prior visits as Respondent failed to document an HPI. Moreover, Respondent's notes of the three visits generally consisted of a single mark through the physical exam. Respondent did note B.L.L.'s total cholesterol was high at 326 and prescribed Lipitor.

17. B.L.L. was seen again on January 9, 2013, for "Refills." Respondent failed to note an HPI. B.L.L.'s blood pressure was 165/97. Respondent's plan included: aspirin, "Dalmane - 30 mg- hangover." Respondent also prescribed Dyazide (triamterene/HCTZ) and Norvasc/amlodipine for B.L.L.'s blood pressure, and Norco for pain.

18. B.L.L. was seen again on February 8, 2013, for refills. Respondent noted this visit illegibly.

[5] A benzodiazepine that is used to treat insomnia.

19. B.L.L. was seen on March 8, 2013, for "Prescription refills, blood pressure." No HPI or exam, other than vitals, were noted. Respondent's Assessment and Plan included "hypertension, obesity, check labs, check sleep study."

20. B.L.L. was seen again on April 5, 2013, and was diagnosed with bicipital tendonitis.[6] However, Respondent noted no HPI or exam relating to this diagnosis. Respondent noted "caution driving," at the bottom of B.L.L.'s chart.

21. B.L.L. was seen again on May 13, 2013, for "lab results." Respondent's plan included: hypertension, low testosterone, and back pain. The remainder of the chart was written illegibly.

22. B.L.L. was seen again on June 12, 2013. Respondent charted the appointment similarly to prior visits, save for a notation stating "Norco – working."

23. During this period B.L.L. received monthly prescriptions for Norco.

24. B.L.L. was seen again on July 10, 2013, for "Rx refills." The chart appeared to be written in handwriting different than Respondent's. The ROS was noted as positive for wearing reading glasses, no constipation with Norco, waking up twice a night to urinate, and back pain with left sided sciatica. The only examination noted included vital signs, and regular heart and lung exams. The assessment was lower back pain, hypertension, high cholesterol and BPH. The note was not signed.

25. B.L.L. was next seen on the following dates: August 14, 2013, September 4, 2013, October 4, 2013, November 7, 2013, December 3, 2013, May 27, 2014, July 9, 2014 and August 11, 2014. None of the charts for these appointments included a legible HPI other than "Rx Refill." The only physical exam included in the chart was vital signs, a diagram of a male figure with scratches over the lower back and the 'crescent' mark through the examination section. Assessments during these visits included back pain, "bs," (which presumably means blood sugar), Androgel, EKG, low testosterone/hypogonadism, HTN (hypertension), Insomnia and High cholesterol. No other plan or prescriptions were documented.

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[6] An inflammatory process of the long head of the biceps tendon and is a common cause of shoulder pain due to its position and function.

26. B.L.L.'s patient file includes notes for at least eight other similar visits between 2013 and 2014, however the noted dates are illegible.

27. B.L.L. was seen on September 9, 2014. No chief complaint or HPI were noted. Examinations performed during the visit included normal head, ear, throat, neck, chest, heart, lung and abdominal exams. Extremities, neurologic, reflexes, sensation and motor all noted as "normal." Respondent's Assessment and Plan were noted as "Hypertension, back pain - chronic low back pain with sciatica and high cholesterol."

28. B.L.L was seen on January 8, 2016. Respondent referred B.L.L. for a low dose chest CT due to B.L.L.'s history of smoking and coronary calcium test result. Respondent also referred B.L.L. to a cardiologist for a consultation and stress test. The recommended tests were never performed and it is unclear why these were ordered as there is no HPI noted.

29. B.L.L. was seen approximately monthly over the entire course of care and the majority of the visits were similar to the above noting only "follow up" or "refills" as the chief complaint with no HPI, ROS, or past history noted. Most of the examinations were either blank or included only a mark through the pre-printed exam portion of the notes with similar scratch marks over the low back of the pre-printed male figure diagram.

30. During the period from 2012 - 2016, B.L.L. failed to complete the recommended MRI or sleep study. During the same period Respondent failed to obtain a CURES report and only one toxicology screening was obtained on May 13, 2013, which revealed opiates but no benzodiazepines. During this time period, Respondent prescribed between 90 and 330 pills of Norco 10 mg per month. Further, Respondent prescribed between 90-180 Valium pills per month, beginning in 2014. Several of the notes generated during this time were not signed and occasionally the notes appear to have been completed by another provider. Many of the notes during the period contain no legible date.

31. B.L.L. died on March 9, 2016. The Respondent completed the death certificate and noted "Cardiac Arrest, Hypercholesterolemia, Hypertension and Obesity" as the cause of death. No autopsy was performed.

32. Over the course of 25 visits, Respondent failed to perform an adequate history or

physical examination as to B.L.L.'s back pain. Further Respondent failed to obtain any testing to confirm a definitive diagnosis for the patient's chronic back pain.

33. Over the course of 25 visits, Respondent failed to document or recommend physical therapy or other treatment modalities or other alternative treatment options to prescribing opiates.

34. Over the course of 25 visits, Respondent never required B.L.L. to sign a Controlled Substance Agreement.

35. Over the course of 25 visits, Respondent never monitored CURES report to determine the extent of B.L.L.'s opiate use.

36. Over the course of 25 visits, Respondent never screened B.L.L. for symptoms of abuse or misuse of opiates, despite B.L.L.'s objective indicators of such.

37. Over the course of 25 visits, Respondent failed to address the various objective signs and symptoms of misuse of opiates with B.L.L.

Patient M.C.

38. M.C. sought treatment from Respondent over a period of approximately ten years for multiple medical issues, beginning as a juvenile. His medical history included fractures of his left wrist and left ankle, Attention Deficit Disorder, neck pain, back pain with spasms, left sciatica and scoliosis. M.C. had a family history of chronic pain and arthritis.

39. On February 13, 2006, M.C. presented with complaints of being "tired [and] fatigue[d]." Respondent's HPI consisted of the term "normal." Respondent's Assessment and Plan included angular chelates[7], fatigue, and was noted illegibly.

40. M.C. was seen on June 7, 2007, for "chest left side hurt." Exam noted was normal and the diagnosis was "left chest wall - boxing."

41. M.C. was seen on December 17, 2007, for "checkup 15 year." Respondent failed to note an HPI, or ROS. The entire exam was noted as "normal." The diagnosis was "10th grader," and the plan was noted illegibly.

42. M.C. was seen on May 28, 2009, for "eyes going blind." The exam was noted as

[7] A condition that causes red, swollen patches in the corners of your mouth where your lips meet and make an angle.

normal and the Assessment and Plan was noted as "vision changes."

43. M.C. was seen on June 15, 2009, for "F/U." Respondent failed to note an HPI or ROS. The exam was noted as "normal." Respondent's assessment was noted as "ocular migraine, back pain and bike."

44. M.C. was seen on March 25, 2010, for a "F/U."(presumably a follow up appointment). Respondent failed to note an HPI or ROS and no exam, other than vital signs, was noted. Respondent's Assessment and Plan were noted as "STD's - broken condoms," and the remainder was noted illegibly.

45 M.C. was next seen on March 3, 2011, for "sore throat since today." No other HPI was noted. Exam is normal other than "+red, +exudates." Respondent's assessment was sinusitis and pharyngitis and M.C. was prescribed Augmentin.[8]

46. M.C. was seen on May 8, 2012, for a "check up and blood test." M.C. was treated by a medical student who recorded the history. M.C. reported having loss of vision in his right eye. M.C. reported recent cold symptoms but no fever, headache, or abdominal pain. The exam was noted as normal and the medical student's assessment was "19 year-old with transient vision loss of the right eye, nodule on penis and atypical palpitations." The plan included referral to an eye doctor (who later diagnosed the patient with an ocular migraine), check Rapid Plasma Reagin[9] test, and consider EKG.

47. M.C. was next seen on June 19, 2012, for "rash for one week on arms and legs." Respondent failed to note an exam, but diagnosed M.C. with "proteinuria[10] and hematuria.[11]"

48. M.C. was next seen on August 1, 2013, for "back pain, body aches." M.C. reported that he suffered multiple falls. Respondent's examination was noted illegibly. Respondent's diagnosis included: "lumbar spine strain, wrist and knee and hematuria and proteinuria." M.C. was advised to return in one month and was prescribed Vicodin ES, Motrin and Soma.

49. M.C. was next seen on April 17, 2015, for a lump on his throat. Respondent failed to

[8] A broad spectrum antibiotic.
[9] A blood test used to screen for syphilis.
[10] Urine that contains an abnormal amount of protein.
[11] The presence of red blood cells in the urine.

note any other history or ROS. Respondent's exam included "Right neck 1 neck node." Respondent's Assessment and Plan included: "check labs, cervical adenitis[12]" and the patient was prescribed Augmentin.

50. The next visit was on August 19, 2015, for a "follow up, [and] Rx refills." Respondent failed to note any history or ROS. The exam consisted of notations on a diagram denoting thoracic and lumbar pain and spasm "4/10 to 2/10." Respondent's assessment included referral to another physician for an abnormal mole, a referral to UCLA genetics, and prescriptions for Ritalin,[13] Norco #60, and Soma #60 "to function for work."

51. M.C. was seen on September 11, 2015, for "Rx refills." The only history noted is "refills for pain, Norco, Soma" and "spasms severe." Exam was noted as "normal," other than scoliosis. Respondent's assessment was "Working and lifting for sits." Respondent ordered lab work and recommended M.C. to seek chiropractic care.

52. On August 20, 2015, August 31, 2015, and September 11, 2015, Respondent refilled M.C.'s prescriptions for Norco #60 and Soma #60, and approximately monthly thereafter. Respondent failed to provide any notation for the aforementioned prescription refills in M.C.'s chart.

53. M.C. was seen again on October 6, 2015, for "follow up lumbar pain." Respondent failed to document a history and failed to record an exam. Respondent's assessment was "blood test panel, Adderall[14] change from Evekeo,[15] return 1-2 months."

54. M.C. was seen again on October 23, 2015, for "follow up lab results." Respondent failed to note a history and the noted exam was "normal." Respondent's Assessment and Plan included "Refilled Soma. Evekeo trial 10 mg BID. Scoliosis back pain, Motrin 600 mg, Yoga, PT, Stretching."

55. M.C. was seen on November 23, 2015, for a "follow up." Respondent noted the history as "work, went well. Anti-depressant." The exam was noted as "normal" and the

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[12] An infection of a lymph node in the neck.
[13] A central nervous system stimulant used to treat attention deficit hyperactivity disorder.
[14] A central nervous system stimulant used to treat attention deficit hyperactivity disorder.
[15] A central nervous system stimulant used to treat attention deficit hyperactivity disorder.

assessment was noted as "Scoliosis, Cough-mucus-Antibiotic and steroid, old ER, Physical therapy. Take meds to get through long days."

56. The next visit date was written illegibly. During that appointment, M.C. presented for "Follow up bumps on neck was spitting up blood." The exam was documented by Respondent's shorthand crescent mark notation. Respondent's assessment was noted as "sore throat, sinusitis, adenitis, low back pain, physical therapy and chiropractic." Respondent prescribed Augmentin.

57. M.C.'s next visit note was not dated, however, he presented for a follow up for "back pain acute." Respondent noted no other history and the exam consisted only of the shorthand crescent checkmark. Respondent's assessment included "Aspen, CO - travel, Scoliosis, mid-back pain spams, Back Rehab-PT and Alkaline water."

58. M.C. was seen on January 26, 2016, for "Follow up back pain." No other HPI or ROS, or exam was noted. Respondent's Assessment and Plan included "Chiropractic Tx last week, Lumbar Tx Norco helps, Mag, X-ray of right foot, Texas travel." The balance of the chart was noted illegibly.

59. M.C. was seen on February 17, 2016. Respondent failed to note a chief complaint, but did note "working as a production assistant. Evekeo help with work focus." Respondent prescribed Norco and Soma as needed and the plan included "Smoking Cessation, Physical therapy recommended, Low back pain - increase with driving, increase stretching, anxiety-work stress and ADD - treatment trial with Evekeo helps with work and stress anxiety."

60. Respondent continued to prescribe to M.C., Soma and Norco, approximately one time per month.

61. M.C. was seen on March 18, 2016, for "Follow up going to Northern California for 6 weeks." Respondent noted the history noted as "no alcohol and pain 2/10 on Norco and 8/10 off of medications." Respondent failed to note any physical examination other than vital signs. Respondent's Plan included "physical therapy, left first toe X-ray and MRI of Lumbar Spine and refills of Norco, Soma and Adderall."

62. M.C.'s next visit was on May 6, 2016 for a "Follow up." Respondent noted the

history as "Acute lumbar strain 9/10, s/p filming production working on sets, with reports of pain and spasms in the low back and left hip." Respondent noted the exam is normal and diagnosed M.C. with "lumbar pain with flare, crash-bike, left hip pain, ADD, physical therapy, meds - caution driving, stretching, yoga."

63. M.C. was seen again on May 31, 2016, for "follow up, acupuncture x 1, physical therapy." M.C. reported working 12 hour days, and complained of pain, fatigue, and weakness in his left leg, and lumbar pain. M.C. stated that Adderall helps with "forms" and he occasionally took ½ of a Soma tablet if he experienced muscle tension. Respondent recommended decreasing to two Norco per day. Additionally, Respondent discussed tolerance, addiction, abuse and driving on the medications. Respondent prescribed Relafen,[16] Norco, Soma and vitamins and recommended lifting restrictions.

64. M.C. was seen again on June 30, 2016, for a "follow up." Respondent noted that M.C. worked 12 hour shifts, had a history of a left wrist fracture, recurrent back strain with severe pain 9/10 with yoga and stretching helping a little." There is no exam other than vitals. Respondent's assessment included "Left wrist pain with early ganglion cyst, right baker's cyst in the knee and ADD." Respondent's plan was noted as recommending Vitamin D and supplements, an X-ray of the left wrist, and providing a prescription for Adderall.

65. M.C. was seen on July 15, 2016, for "going to the valley, off work today." M.C. complained of pain on extension with 9/10 spasms and history of scoliosis. Respondent charted no exam other than weight and asymmetric reflexes noted on a diagram. Respondent diagnosed M.C. with low back pain and ordered an MRI of the lumbar spine. Respondent refilled M.C.'s medications and recommended physical therapy.

66. M.C. was seen on August 10, 2016, for review of the MRI. Respondent noted no exam or history. M.C. was referred to a spine specialist and prescribed Norco and Soma and advised to avoid heavy lifting.

67. M.C. was seen on August 19, 2016. Respondent noted minimal history and no examination. Respondent refilled M.C.'s medications. M.C. was again referred to a spine

[16] A nonsteroidal anti-inflammatory drug.

specialist and advised to avoid lifting.

68. M.C. was seen on September 1, 2016. Respondent noted minimal history and no examination. Respondent refilled M.C.'s medications. M.C. was again referred to a spine specialist and advised to avoid lifting.

69. M.C. was seen on September 15, 2016, for "follow up nerve conduction." M.C. reported left foot numbness and that the prescribed Flector[17] patch caused gastrointestinal issues, and Neurontin[18] caused over-sedation. Respondent recorded M.C.'s vital signs, and conducted reflexes and positive straight leg raise testing. No nerve studies were reviewed. M.C. was prescribed Soma as needed, Flexeril,[19] Norco, and physical therapy.

70. On or about September 2016, M.C. received Suboxone and Alprazolam from another physician.

71. M.C. was seen on October 6, 2016 for a "follow up." M.C. was diagnosed with a bulging disc, was prescribed Norco and Soma, and was encouraged to quit smoking. M.C. indicated he would be traveling for 6 weeks and that the pain improved from 9/10 to 3/10 with medications.

72. On or about October 18, 2016, Respondent received a letter from CVS Pharmacy regarding M.C.'s receipt of both Norco and Suboxone[20] (Respondent had not prescribed Suboxone to M.C.).

73. On or about November 10, 2016, Respondent telephoned M.C. and discussed the substance of the CVS letter. M.C. reported he was working out of the area and experienced an increase in back pain due to a bike ride. M.C. reported increased pain and stiffness and he had no time to go to physical therapy.

74. On or about November 1, 2016, Respondent sent a response to the letter from CVS, noting "pt claims that someone has stolen his HealthCare ID and is getting medications using his health care. I was not aware of buprenorphine with this patient."

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[17] A nonsteroidal anti-inflammatory drug.
[18] An anticonvulsant drug that is used to treat nerve pain.
[19] A muscle relaxant.
[20] An opioid medication used to treat opiate addiction.

75. M.C. was seen on December 2, 2016 for follow up and reported working long hours and taking Adderall without insomnia. The only exam noted was "no focal neuro defects." Respondent advised M.C. to try reduce his daily intake of Norco. Respondent refilled M.C.'s prescription for Adderall and, again, referred M.C. to a spine specialist.

76. M.C. was next seen on December 12, 2016, for a "follow up." M.C. reported he was working and denied any side effects of medications. Additionally, M.C. reported an improvement of his pain from a 9/10 to a 3/10 while using Norco and Soma. M.C. recently aggravated his pain by "lifting car parts." and had an exacerbation of his pain as well as paresthesias[21] of his left foot. M.C. also reported gastrointestinal pain which improved when he stopped taking Relafen and Motrin. M.C. further reported that Adderall helped with his work, but did not take it on some weekends. Respondent encouraged physical therapy, checked M.C.'s labs, and encouraged smoking cessation and follow up in one month. The only exam noted was reflexes and vital signs.

77. On or about February 3, 2017, M.C. had a repeat MRI of his lumbar spine on February 3, 2017 which noted some progression of his disc changes compared to the prior imaging.

78. On or about February 13, 2017, M.C. was seen at the UCLA Hospital emergency room for a drug overdose.

79. On or about April, 2017, M.C. sought treatment from a spine specialist who recommended a surgical microdiscectomy[22] for his disc disease.

80. Respondent continued to treat M.C. through 2017 prescribing Norco and Soma and Adderall on a monthly basis.

81. Over the course of treatment, Respondent performed one Adult Attention Deficit Scale with respect to M.C. However, the chart has no name or completion date.

82. Over the course of treatment, Respondent failed to perform an adequate history or proper psychological testing to properly diagnose M.C. with ADHD.

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[21] An abnormal sensation of the body, such as numbness, tingling, or burning.

[22] A surgery to remove lumbar herniated disc material that is pressing on a nerve root or the spinal cord.

83. Over the course of treatment, Respondent never required M.C. to sign a Controlled Substance Agreement.

84. Over the course of treatment, Respondent never monitored CURES report to determine the extent of M.C.'s opiate use.

85. Over the course of treatment, Respondent performed one toxicology screening on M.C., on December 13, 2007 which was negative for opiates and stimulants. During the period Respondent prescribed opiates to M.C., Respondent never performed a toxicology screening to determine the extent of M.C.'s opiate use.

86. Over the course of treatment, Respondent failed to address the various objective signs and symptoms of misuse of opiates with M.C.

FIRST CAUSE FOR DISCIPLINE

(Excessive Prescribing)

87. Respondent Steven Ivan Popkow, M.D. is subject to disciplinary action under section California Business and Professions Code section 725, and 2241.5, subdivisions (c) and (d), in that Respondent prescribed excessive amounts of schedule II substances to B.L.L. and M.C. The circumstances are as follows:

88. The facts and circumstances regarding this Cause for Discipline are alleged in paragraphs 10 through 86 above, and are hereby incorporated by reference and realleged as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Without Indication)

89. Respondent Steven Ivan Popkow, M.D. is subject to disciplinary action under California Business and Professions Code section 2242 and California Health and Safety Code section 11153, in that Respondent failed to preform adequate examinations of B.L.L. and M.C. prior to continuously prescribing Schedule II substances. The circumstances are as follows:

90. The facts and circumstances regarding this Cause for Discipline are alleged in paragraphs 10 through 86 above, and are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

91. Respondent Steven Ivan Popkow, M.D. is subject to disciplinary action under California Business and Professions Code section 2234, subdivision (b), in that Respondent's departure from the standards of care during the treatment of B.L.L. and M.C. constitutes gross negligence. The circumstances are as follows:

92. The facts and circumstances regarding this Cause for Discipline are alleged in paragraphs 10 through 86 above, and are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

93. Respondent Steven Ivan Popkow, M.D. is subject to disciplinary action under California Business and Professions Code section 2234, subdivision (c), in that Respondent engaged in repeated acts of negligence during the course of care and treatment of B.L.L. and M.C. The circumstances are as follows:

94. The facts and circumstances regarding this Cause for Discipline are alleged in paragraphs 10 through 86 above, and are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

95. Respondent Steven Ivan Popkow, M.D. is subject to disciplinary action under California Business and Professions Code section 2234, subdivision (d), in that Respondent departure from the standard of care during the course of treatment of B.L.L. and M.C. constitutes incompetence. The circumstances are as follows:

96. The facts and circumstances regarding this Cause for Discipline are alleged in paragraphs 10 through 86 above, and are hereby incorporated by reference and realleged as if fully set forth herein.

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SIXTH CAUSE FOR DISCIPLINE

(Record Keeping)

97. Respondent Steven Ivan Popkow, M.D. is subject to disciplinary action under Business and Professions Code section 2266, in that Respondent failed to adequately documents numerous visits with B.L.L. and M.C. The circumstances are as follows:

98. The facts and circumstances regarding this Cause for Discipline are alleged in paragraphs 10 through 86 above, and are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

99. Respondent Steven Ivan Popkow, M.D. is subject to disciplinary action under California Business and Professions Code section 2234, subdivision (a) in that Respondent's failure to competently treat B.L.L. and M.C. constitutes unprofessional conduct. The circumstances are as follows:

100. The facts and circumstances regarding this Cause for Discipline are alleged in paragraphs 10 through 86 above, and are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 62006, issued to Steven Ivan Popkow, M.D.;

2. Revoking, suspending or denying approval of Steven Ivan Popkow, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Steven Ivan Popkow, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: December 29, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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